Sample Medical History

Name: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Age: _____ Referred by: _____

Have you ever had the following?

- ☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre- cancerous lesions such as multiple dysplastic nevi.
- ☐ Any active infection.
- ☐ Diseases which may be stimulated by light, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Use of photosensitive medication and/or herbs that may cause sensitivity to light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
- ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
- ☐ Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
- ☐ History of bleeding coagulopathies, or use of anticoagulants
- ☐ History of keloid scarring.
- ☐ Very dry skin.
- ☐ Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.
- ☐ Are you pregnant? ☐ Yes ☐ No
- ☐ What medications are you taking (including aspirin)? _____
- ☐ Daily consumption of alcohol _____
- ☐ Allergies: _____
- ☐ Are you taking any herbal preparations? (St. John's Wort, etc.) _____

If yes, list _____

☐ Do you wear contact lenses? ☐ Yes ☐ No

Skin type (when exposed to the sun without protection for about 1 hour)

- ☐ always burns, never tans
- ☐ always burns, sometimes tans
- ☐ sometimes burns, sometimes tans
- ☐ always tans
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Black
- ☐ Asian
- ☐ Middle Eastern

When were you last exposed to the sun (including a tanning booth)? _____

Do you use chemical sun tanning lotions? _____ Are you planning a holiday in the sun? _____

Reason for visit (area to be treated) _____

Prior treatment (if any) _____

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Sample Soprano Laser Log

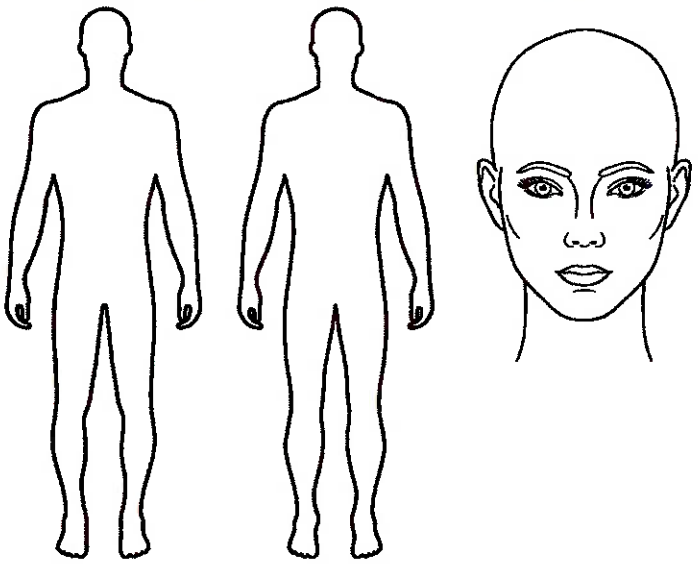
Name: _____ Date: _____

- Pregnant or Nursing? (circle) Y / N
- Any Recent Change in Medication or Medical History? ***(Rx / Fillers / Botox)?:*** Y / N
  If yes, explain: _____
- Any Side Effects/Concerns From Any Previous Treatments? (Swelling, Crusting, Blistering) Y / N
  If yes, explain: _____
- What changes or improvements to your skin and/ or hair growth patterns have you or others noticed?
  _____
- Sun Exposure: Any Recent Self Tanner or Direct Prolonged Sun Exposure ***with or without SPF*** in the past 4 weeks? Y / N
  How long ago and Length of time of exposure? _____

Checklist:

_____ Consent signed: Y / N
_____ Tx Site Cleaned: Y / N
_____ Eye Protection: **Goggle or Shields**
_____ Applied: SPF (#) Other: _____
_____ Post Laser Care Discussed: Y / N

Fitzpatrick Skin Type (circle one) I II III IV V VI



Tx# _____ last tx date _____
Body Area: _____
Tx Head: _____ nm
Pulse Width: _____
Fluence (J/cm²): _____
Total Energy Delivered (KJ): _____
Pulses: _____

Tx# _____ last tx date _____
Body Area: _____
Tx Head: _____ nm
Pulse Width: _____
Fluence (J/cm²): _____
Total Energy Delivered (KJ): _____
Pulses: _____

Notes: _____

Provider Signature: _____ Date: _____

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Fitzpatrick Skin Type

The most commonly used scheme to classify a persons skin type by their response to sun exposure in terms of the degree of burning and tanning was developed by Thomas B. Fitzpactrick , MD, PhD.

YOUR EYE COLOR:
0. LIGHT COLORS
1. BLUE, GRAY OR GREEN
2. DARK
3. BROWN
4. BLACK

YOUR NATURAL HAIR COLOR:
0. SANDY RED
1. BLONDE
2. CHESTNUT OR DARK BLONDE
3. BROWN
4. BLACK

YOUR SKIN COLOR:
0. REDDISH
1. PALE
2. BEIGE OR OLIVE
3. BROWN
4. DARK BROWN

DO YOU HAVE FRECKLES:
0. MANY
1. SEVERAL
2. FEW
3. RARE
4. NONE

IF YOU STAY IN THE SUN TOO LONG, WHAT HAPPENS TO YOUR SKIN?
0. PAINFUL BLISTERS, PEELS
1. MILD BLISTERS, PEELING
2. BURN, MILD PEELING
3. RARE
4. NO BURN

AFTER SUN EXPOSURE, DO YOU TURN BROWN?
0. NEVER
1. LIGHT TAN
2. SOMETIMES
3. OFTEN
4. ALWAYS

HOW BROWN DO YOU GET?
0. NEVER
1. LIGHT TAN
2. MEDIUM TAN
3. DARK TAN
4. DEEP TAN

IS YOUR FACE SENSITIVE TO THE SUN?
0. VERY SENSTIVE
1. SENSITIVE
2. SOMETIMES
3. RESISTANT
4. NEVER HAVE A PROBLEM

HOW OFTEN DO YOU TAN/ OR EXPOSE THE AREA TO BE TREATED TO THE SUN?
0. NEVER
1. SELDOM
2. SOMETIMES
3. OFTEN
4. ALWAYS

WHEN WAS YOUR LAST TAN/ SUN EXPOSURE?
0. +3 MONTHS AGO
1. 2-3 MONTHS AGO
2. 1-2 MONTHS AGO
3. WEEKS AGO
4. DAYS

Score	
0-6	**SKIN TYPE I** ALWAYS BURNS, NEVER TANS (PALE WHITE SKIN)
7-13	**SKIN TYPE II** ALWAYS BURNS EASILY, TANS MINIMALLY (WHITE SKIN)
14-20	**SKIN TYPE III** BURNS MODERATELY, TANS UNIFORMLY (LIGHT BROWN SKIN)

Required for Skin Analysis & Treatment*

Your Ethnicity: _____

Mother's Ethnicity: _____

Father's Ethnicity: _____

Are you tan? Y N

Do you use: Tanning beds Spray tan Sun

Date of Last Sun Exposure: _____

Duration of Exposure: _____

Your Fitzpatrick: _____

This information is not intended to take the place of medical advice. Please seek advice from a qualified professional.

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Laser Hair Reduction Consent

Patient Name _____

Treatment Sites: *(check all that apply)*

☐ full face	☐ bikini	☐ upper back	☐ upper legs
☐ fingers	☐ lip	☐ Brazilian	☐ lower back
☐ Feet	☐ toes	☐ chin	☐ other: _____
☐ Neck	☐ Brow	☐ hands	
☐ upper arms	☐ Chest	☐ underarms	_____
☐ lower legs	☐ lower arms	☐ Abdomen	_____

I duly authorize _____ to perform the IPL/DIODE Laser Hair Removal procedure.

_____ **Patient's initials**: I understand that the IPL/Laser is a device used for hair removal and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising, and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

_____ **Patient's initials**: Clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that epilation with the IPL/Laser system is a safe alternative to methods used for removing unwanted hair, such as shaving, waxing, chemical epilation, and electrolysis.

_____ **Patient's initials**: I understand that treatment by the IPL/Laser hair removal system involves a series of treatments, and the fee structure has been fully explained to me.

_____ **Patient's initials**: I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____ **Patient's initials**: I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit and/or promotion.

I understand it is recommended that I have between 6-10 treatments for optimal results and follow up with maintenance treatments as needed to maintain my results.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient's Name (print) : _____

Patient's Signature_____Date_____

Witness_____ Date_____

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